Dear parent or guardian:

Complete this form and give it to the adult who will be caring for your child in your absence. This form should be presented to the physician if your child should need medical treatment when you are not available. For additional forms, contact your Affinity Medical Group physician office.

Medical and Insurance Information

Child's Name and Date of Birth _____

Address _____

Father's Name _____ Home Phone _____

Employed at _____ Business Phone _____

Mother's Name _____ Home Phone _____

Employed at _____ Business Phone _____

Child's Doctor _____

Doctor's Address and Phone Number _____

Child is Allergic to _____

Medical Information (last Tetanus shot, major illness) _____

_____

Child's Medical History Number _____

Insurance Company and Policy Numbers _____

Financially Responsible Party _____

I, the undersigned parent/guardian of _____ , in the event I cannot be contacted through reasonable efforts, hereby grant to _____ my permission to consent to and authorize medical and hospital care and treatment for the above named child/ward. This authorization shall be valid from _____ , 20 _____ through _____ , 20 _____ (**1 year later**). I do hereby indentify and hold harmless Affinity Medical Group and any physician, hospital or other health care provider or person acting in reliance upon this authorization.

_____ _____

Patient/Legal guardian signature Date Witness signature Date

Copy or facsimile is as valid as original

Affinity HEALTH SYSTEM

- ❑ Affinity Medical Group
- ❑ Affinity Occupational Health
- ❑ Calumet Medical Center
- ❑ Franciscan Care Center
- ❑ Mercy Medical Center
- ❑ Network Health Plan
- ❑ St. Elizabeth Hospital
- ❑ _____

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AUTHORIZATION OF SUBSTITUTED CONSENT FOR TREATMENT OF CHILD

Patient Identification